Appendix M: Medicare Crossover Claim Payment Methodology

> **Crossover Payment Methodology**
> **Professional Services (CMS-1500, 837P)**
> **Refer to WAC 388-517-0320**
>
> - Medical Assistance compares the Medical Assistance allowed amount to Medicare's allowed amount for the service, selects the lesser amount of the two, then deducts Medicare's payment from the amount selected.
> - If there is a balance due, Medical Assistance pays the client's cost sharing liability (deductible, coinsurance, or co-pay) up to the lesser of the allowed amounts.
> - If there is no balance due, Medical Assistance does not make any crossover claim payment because Medicare's payment exceeds the lesser of the allowed amounts.

The Agency cannot make direct payments to clients to cover the client's cost sharing liability (deductible, coinsurance, or co-pay) amount of Part B Medicare claim. The Agency **can** pay these costs to the provider on behalf of the client when:

- The provider **accepts** assignment; and
- The total combined payment to the provider from Medicare and Medical Assistance does not exceed Medicare or Medical Assistance's allowed amount for the service, whichever is less.

Note: The Agency is revising **codes** that may be noncovered by Medical Assistance, but the services are covered. If the service is covered by Medical Assistance, but the code is not, then the Agency may pay as follows:

Medicare Allowed – Medicare Paid = The Agency payment

Every effort has been made to ensure this guide's accuracy. However, in the unlikely event of an actual or apparent conflict between this document and a Agency rule, the Agency rule controls.

139

Institutional Services (UB-04, 837I)
Crossover Payment Methodology
Institutional Services (UB-04, 837I)

- Outpatient Hospital
  - Payment equals the lesser of Medical Assistance allowed amount minus the Medicare paid amount up to the client's cost sharing liability (deductible, coinsurance, or co-pay).

- RHC-Rural Health Clinic
  - For RHCs who bill for Medicare Encounteer Services payment equals the Rural Health Clinic (RHC) Per Diem rate on file with the Agency minus the Medicare paid amount. These RHC claims are submitted using Type of Bill 71x and Billing provider Taxonomy 261QR1300X.

- FQHC-Federally Qualified Health Clinic
  - For FQHCs who bill for FQHC Encounteer Services, payment equals the Medicare coinsurance amount. These FQHCs bill crossover claims using Type of Bill 73x and Billing Provider Taxonomy 261QF0400X.

- Inpatient Hospital for client with both Medicare Part A and Part B coverage
  - Payment equals **the lesser of** Medical Assistance allowed amount minus the Medicare paid amount, up to the client's cost sharing liability (deductible, coinsurance, or co-pay).

Note: The Agency would adjust any payment amounts if the client has a Commercial Medicare supplement policy (TPL) and that supplement payer makes a payment after Medicare. In that case the formula would be:

Medical Assistance allowed – Medicare Paid – TPL Paid = The Agency payment

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140